3D image of sclerosing adenosis

Mammogram of sclerosing adenosis

Mammography Education, Inc.

2020

BREAST SEMINAR SERIES

Faculty

LÁSZLÓ TABÁR, MD, FACR (Hon) Course Director
Professor emeritus of Radiology

Detection and Diagnosis of Breast Diseases Using the Multimodality Approach

A FULLY INTERACTIVE, UNIQUE LEARNING EXPERIENCE

NEW course design

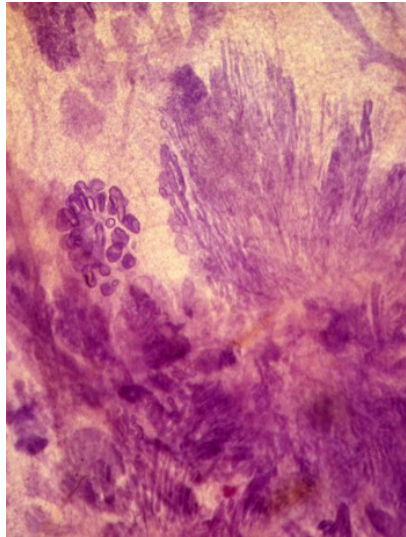*Nov 17 - Nov 20, 2020*
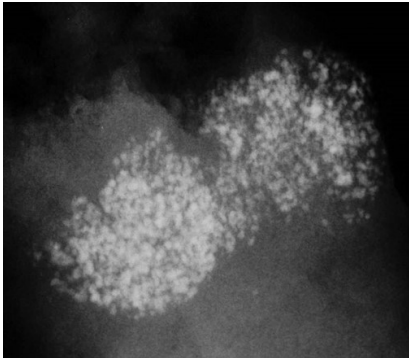**TORINO**, *Italy*

Centro Congressi Unione Industriale

Il corso verrà accreditato per:
Medico Chirurgo specializzato in: oncologia, radioterapia, chirurgia generale, chirurgia plastica e ricostruttiva, ginecologia e ostetricia, anatomia patologica, medicina nucleare, patologia clinica, radiodiagnostica, medicina generale ed epidemiologia; TSRM
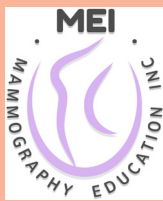
This course provides extensive knowledge about diagnostic breast imaging, differential diagnosis of breast diseases, implications for management and newest diagnostic technologies

2020
BREAST SEMINAR SERIES of MEI

Detection and Diagnosis of Breast Diseases
Using the Multimodality Approach. An interactive course.

László Tabár, MD, FACR (Hon)
Course Director

FACULTY

László Tabár, MD, FACR (Hon).
Course Director

*Professor emeritus of Radiology,
Department of Mammography
Falun, Sweden*

Alfonso Frigerio, M.D.
*Director of Mammography Screening
Regional Reference Center for
Breast Cancer Screening,
CPO-Piemonte,
AOU Città della Salute e della Scienza,
Torino, Italy*

Photographs from the collection of the non-profit Tabar Foundation
dedicated to Research and Education for Breast Cancer,
Visit: tabarfoundation.org

II

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Course Director

Mammography Education, Inc. is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. Mammography Education, Inc. designed these medical education activities for a maximum of **26 credit hours inCategory I** of the Physicians' Recognition Award of the American Medical Association. Each physician should claim only those hours of credit that he / she actually spent in the educational activity.

NEW COURSE DESIGN

* The lectures on each major subject will be followed by **interactive screening sessions** consisting of a mixture of normal and early cancer cases presented on the large screen exactly as they appear on a viewing station at screening. Using a specially provided polling program downloaded to each participant's smartphone or tablet, the attendees will be asked to vote anonymously on each case. The aggreate results will appear instantly for discussion and evaluation. This new course design gives immediate feedback demonstrating the effectiveness of various screening methods.

* During the course the attendees will progressively **improve their interpretive expertise**, as they learn the full spectrum of normal breast images, with all important findings explained with the help of 3-dimensional histology images.

* These skills will lead to **fewer call-backs** and greater confidence in reading a large number of mammograms.
* **Immediate feedback** and discussion of every case throughout every reading session.
* Special emphasis will be placed on **finding early phase breast cancers.**
* All abnormal cases are fully worked up and the **complete imaging workup will be presented in detail, including ultrasound, MRI and large section histopathology.**

CREDITS

We would like to thank the sponsors for their support of the teaching seminars of Mammography Education, Inc (list of vendors will be presented at the beginning of the course)

III

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BREAST SEMINAR SERIES of MEI

Detection and Diagnosis of Breast Diseases
Using the Multimodality Approach. An interactive course.

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Course Director

Day 1 Nov 17   Morning lectures between 8:30 AM - 12:00 PM.   Breaks: 10:00 AM, 11:00 AM

8:30 AM   INTRODUCTION FOLLOWED BY DIDACTIC LECTURES COVERING:

• A NEW ERA in the DIAGNOSIS and TREATMENT of BREAST CANCER. A historical perspective.
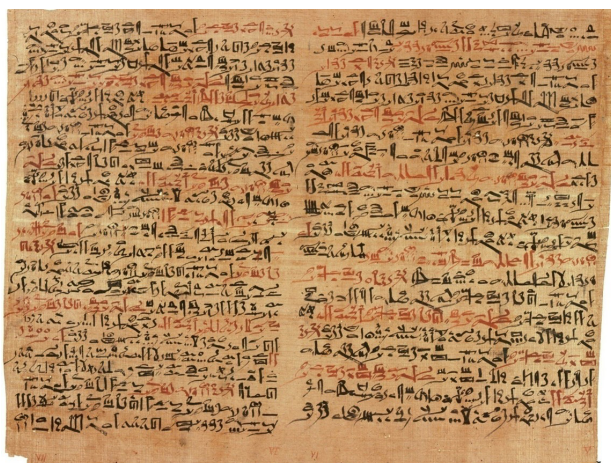
The Edwin Smith papyrus

葛洪（283年－343年）
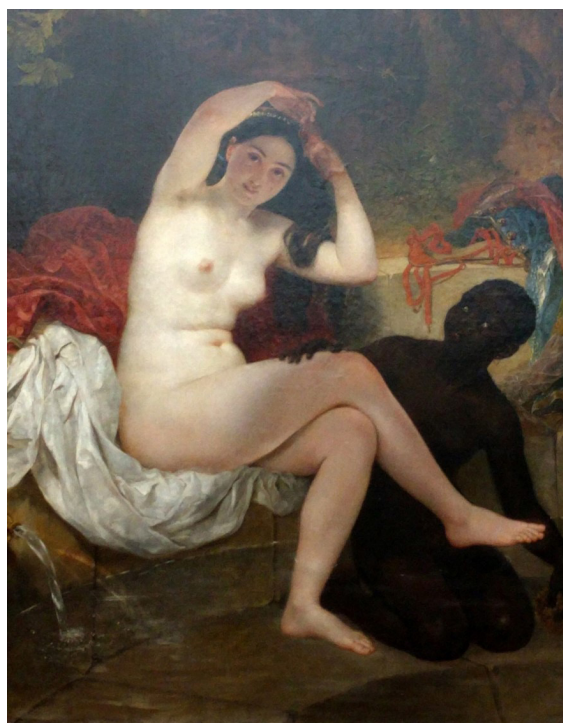东晋**Master Hong Ge**

《肘後備急方》其卷五
治癰疽、妬乳諸毒腫方
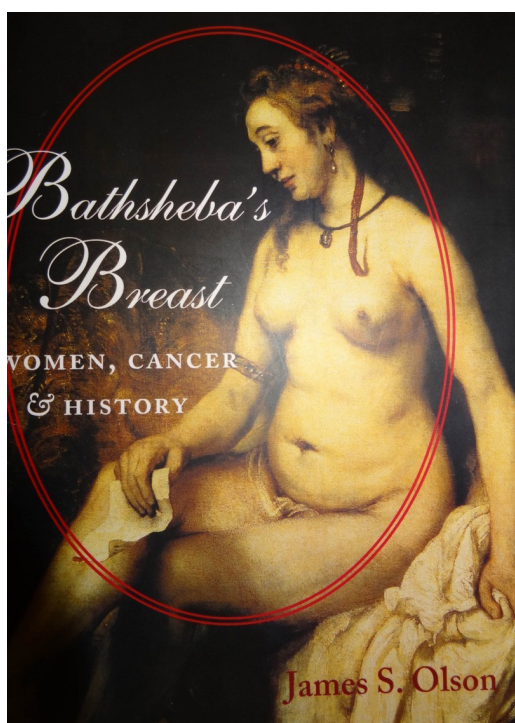**"Hard as Rock"**
「癰結腫堅如石，或如
大核，色不變，或做石
癰不消」**No Change in
Skin Color**

Tu Youyou,
Chinese pharmaceutical chemist, 2015 Nobel Prize in Physiology or Medicine.
Got the idea from **same book** and discovered artemisinin and dihydroartemisinin with
colleagues, used to treat malaria, which has saved millions of lives.

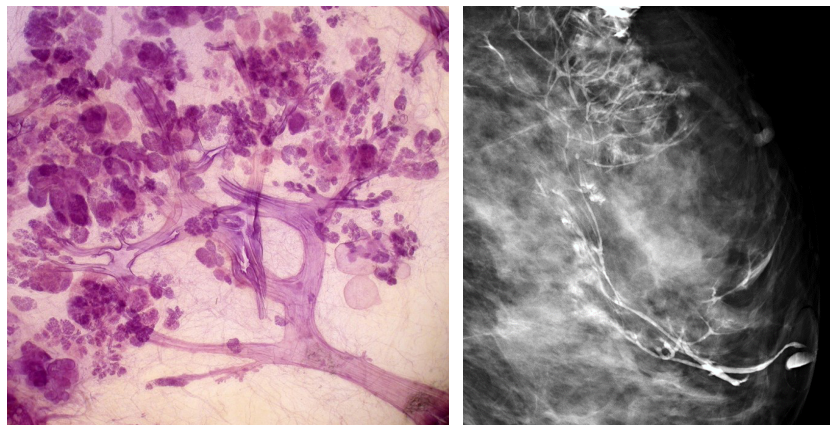The young Bathsheba by Briullov,
Moscow, Tretyakovo museum

Rembrandt's painting of Bathsheba

IV

MEI
MAMMOGRAPHY EDUCATION INC

2020
BREAST SEMINAR SERIES of MEI

Detection and Diagnosis of Breast Diseases
Using the Multimodality Approach. An interactive course.

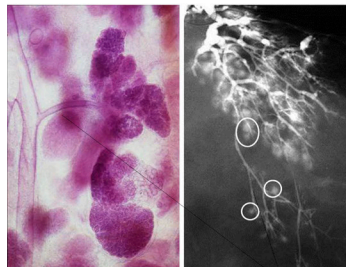**László Tabár, MD, FACR (Hon)**
Course Director

A major technical development in the mid-70s: the invention of *low dose film-screen mammography* made it possible to find breast cancers in their non-palpable phase.
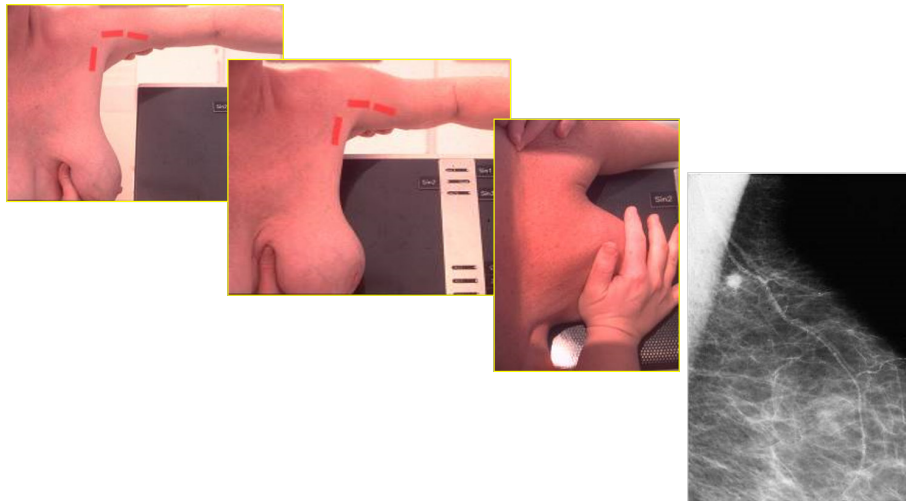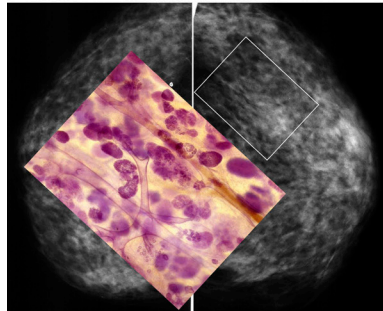

• **THE MAGICAL ROLE OF LARGE FORMAT, SUBGROSS HISTOPATHOLOGY IN TRAINING**

• Correlating 3-dimensional, subgross anatomy with mammography of the normal breast results in **increased confidence in reading a mammogram** *and* **finding small abnormalities**. Special training in large format thin and thick section (stereoscopic) histopathologic correlation enables the radiologist to account for every linear and nodular density on the mammogram.


v

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NORMAL BREAST ANATOMY

Three of the four basic building blocks (TDLU, ducts and fibrous tissue) are discernable on this 3D histology slice.

A lobule consists of 40-60 ductules / acini. This is the site of milk production and also 75% of breast cancers originate from the cells lining the acini (AAB, acinar adenocarcinoma of the breast).
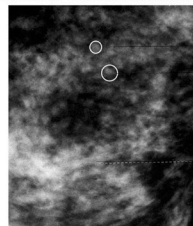
TDLUs on 3D histology and on a galactogram.   Terminal duct

Illustration of subgross breast anatomy using 3D histologic-mammographic comparison..
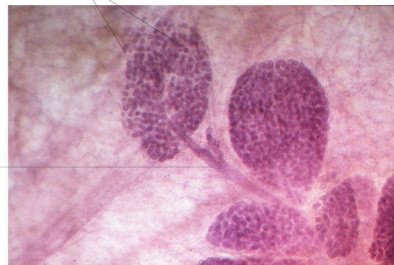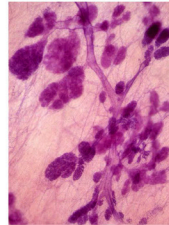
Large format thick section (subgross, 3D) histology image of neighboring TDLUs. The lobule and the terminal duct combined are termed "Terminal Ductal Lobular Unit (TDLU).
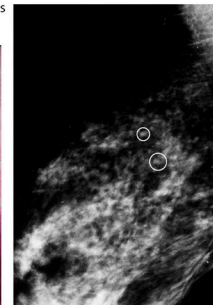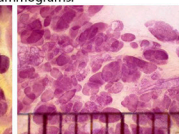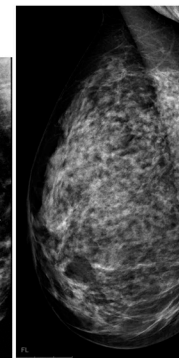
Three of the four basic building blocks (TDLU, ducts and adipose tissue) are discernable on these mammograms.

TDLUs

Milk ducts

The size of a normal TDLU varies between 0.7 - 1.5 mm.

TDLUs   Lactiferous ducts   Fibrosis

TDLUs

Large TDLUs Adenosis

Ducts

Adipose tissue

Fibrous tissue
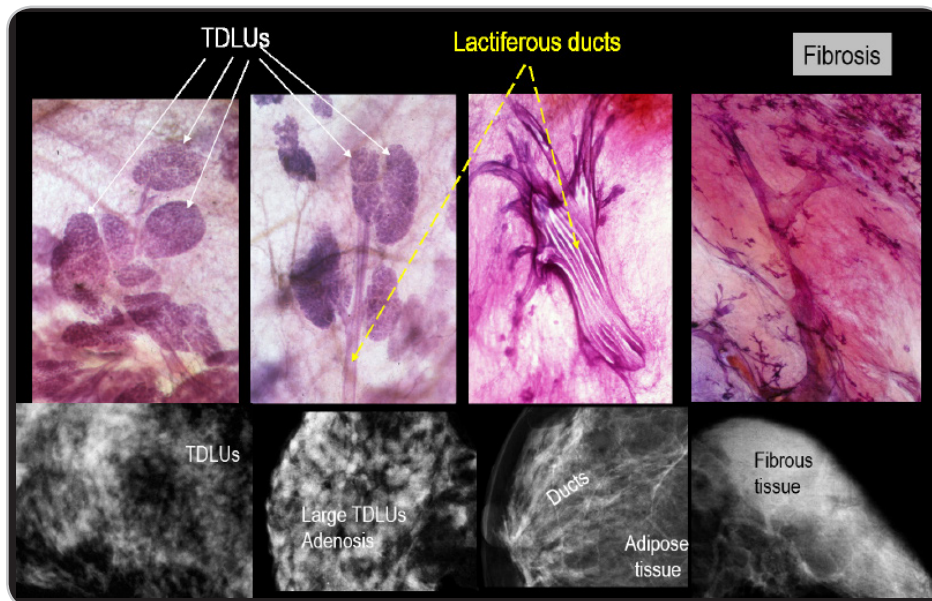
The breast, unlike any other organ, has **five structurally different mammographic parenchymal** patterns.

12:00 PM - 1:00 PM   L u n c h

VI

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Detection and Diagnosis of Breast Diseases
Using the Multimodality Approach. An interactive course.

László Tabár, MD, FACR (Hon)
Course Director

## Day 1   Afternoon lectures: 1:00 PM - 5:30 PM.   Breaks at 2:30 and 3:30 PM

ALGORITHM FOR CLASSIFYING BREAST DISEASES ACCORDING TO THEIR SITE OF ORIGIN

HOW TO FIND THE INVASIVE BREAST CANCER WHEN IT IS STILL SMALL. *Malignant stellate and circular/oval-shaped lesions originating from the TDLUs (AAB)*: clinical presentation, histology, mammographic - MRI - ultrasound appearance and outcome.
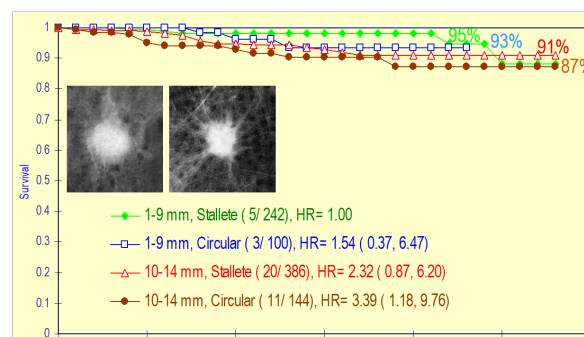
- A systematic method for viewing mammograms. Areas on the mammogram where most breast cancers will be found. Viewing dense breasts. Viewing relatively easy-to-read breasts.

- The role of hand-held ultrasound / 3D automated ultrasound / MRI in the detection and workup of the findings. The multimodality approach
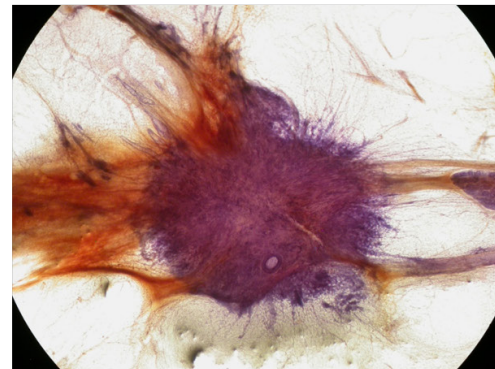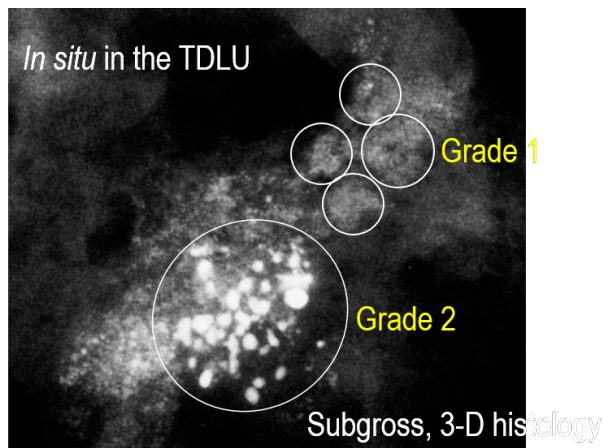
- **Interactive screening session:** Using what has just been taught, each participant will assess a mixture of normal and early cancer cases, and vote anonymously using a smartphone or tablet. The combined results will appear instantly for discussion. and evaluation.

We use a classification system which is based on the apparent anatomic site of origin of breast cancer since the long-term patient outcome appears to be largely determined by the site of origin of breast cancer.

a) Terminal ductal lobular units (TDLU) (AAB) (75%)
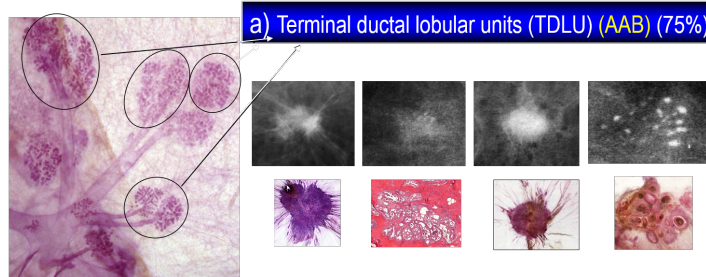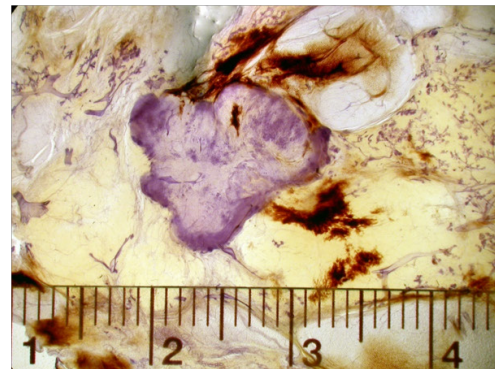
with no associated calcifications on the mammogram. Women 40-69 yrs old, diagnosed in Dalarna county, Sweden between 1977-2006

Survival chart:
- 1-9 mm, Stallete (5/ 242), HR= 1.00
- 1-9 mm, Circular (3/ 100), HR= 1.54 (0.37, 6.47)
- 10-14 mm, Stallete (20/ 386), HR= 2.32 (0.87, 6.20)
- 10-14 mm, Circular (11/ 144), HR= 3.39 (1.18, 9.76)

95%   93%   91%   87%

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Course Director

In situ in the TDLU

Grade 1

Grade 2

Subgross, 3-D histology

Invasive

Garde 1 and 2 carcinoma i*n situ* in the TDLUs, not DCIS. The subsequent invasive carcinoma is either a stellate or circular tumor mass (not invasive "ductal" carcinoma), well demonstrable on the mammogram.
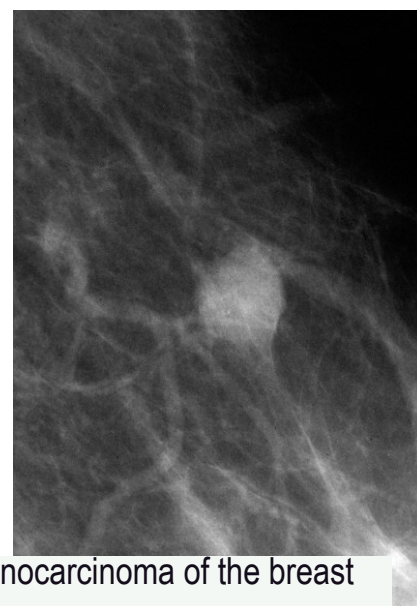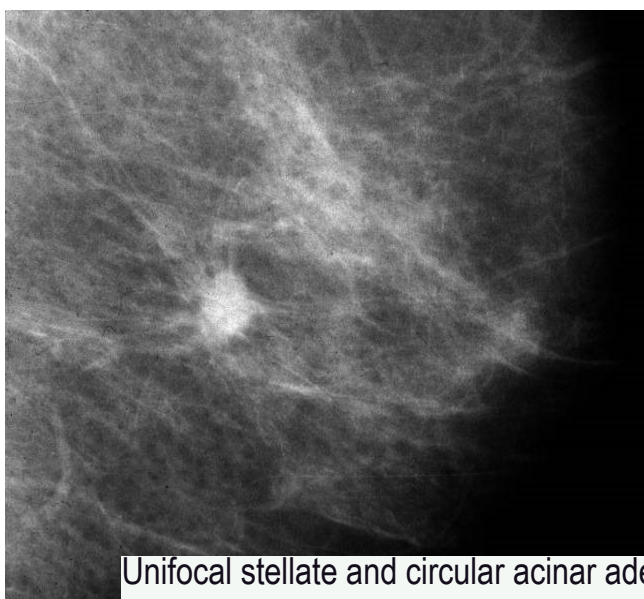
Unifocal stellate and circular acinar adenocarcinoma of the breast

VIII

![MEI Mammography Education Inc logo]

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Multifocal acinar adenocarcinoma of the breast

Specimen slice radiograph showing multifocal invasive cancers

5:30 PM. End of Day 1.

IX

![MEI Mammography Education Inc. logo]

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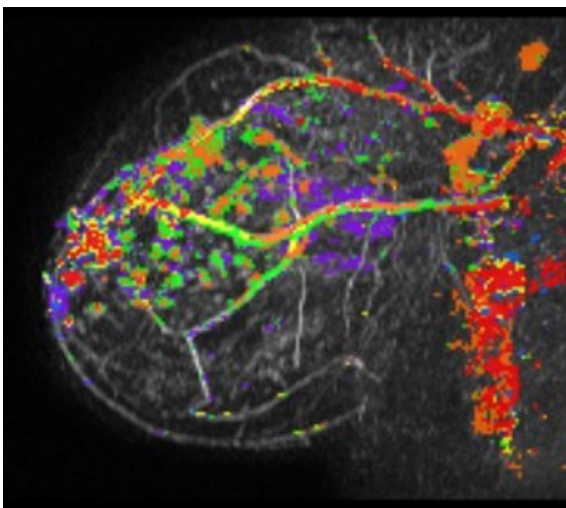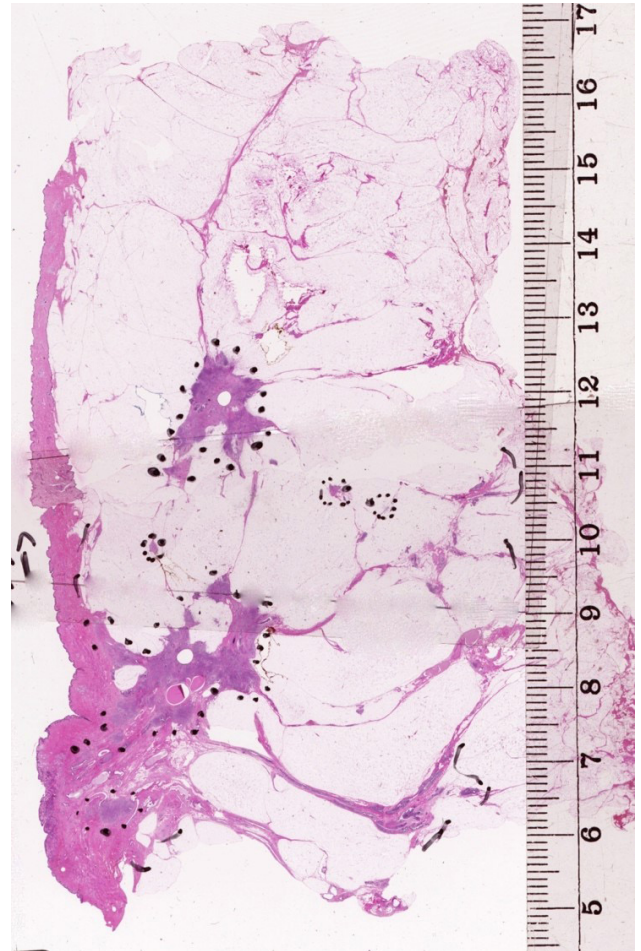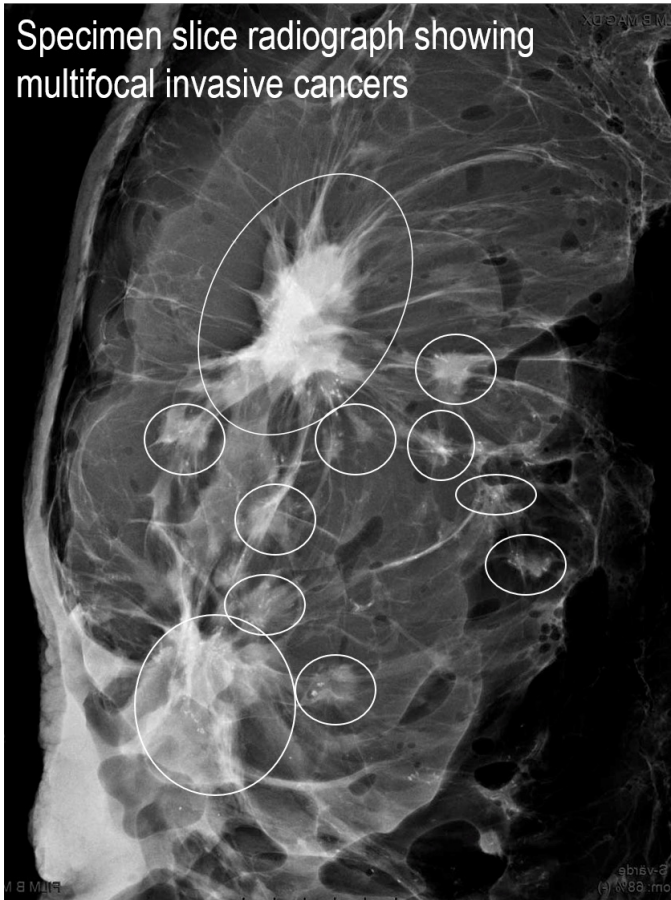
Day 2 Nov 18 **Morning lectures between 8:30 AM - 12:00 PM.**   **Breaks: 10:00 AM, 11:00 AM**

Diffuse breast canceer originating from the major lactiferous ducts (DAB) (**duct forming invasive carcinoma**, not "DCIS")
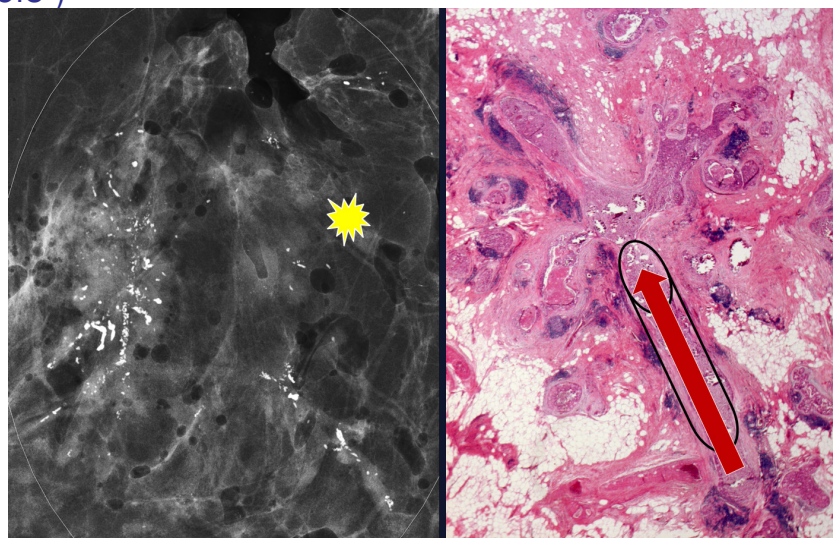
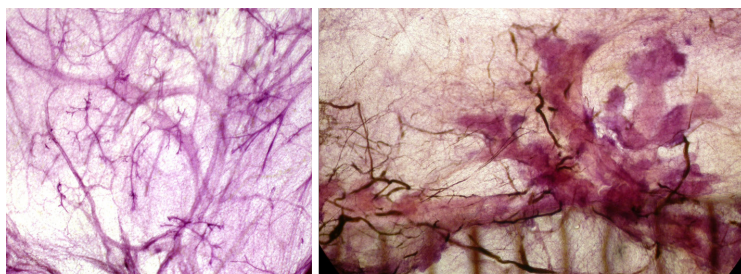

Mammographic-histologic correlation: 60x30 mm Gr 3 duct forming invasive cancer (DAB) and a 6x3 mm poorly differentiated AAB.

Cumulative survival of women aged 40-69 years with 1-14 mm invasive breast cancers by mammographic tumor features. Dalarna county, Sweden.

AAB

100%
94%
93%
88%
65%

DAB

Cumulative Survival

- △ Powdery calcifications +- tumor mass (0/ 49), HR= 0.00 (. , .)
- ● Stellate without calcifications (19/ 569), HR= 1.00
- ■ Crushed stone-like calcifications +- tumor mass (2/ 80), HR= 0.80 (0.19, 3.43)
- ■ Circular/oval without calcifications (12/ 216), HR= 1.62 (0.78, 3.33)
- ■ Casting type calcifications +- tumor mass (17/ 69), HR= 8.91 (4.63, 17.17)

Year since diagnosis

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INTERACTIVE LECTURE SERIES WILL COVER THE FOLLOWING TOPICS.

ALGORITHM FOR CLASSIFYING BREAST DISEASES ACCORDING TO THEIR SITE OF ORIGIN

Breast diseases originating in the major ducts

- **Benign type calcifications** originating in the major ducts

    a) Secretory disease type calcifications

- **Malignant type calcifications** originating in the major ducts

- **Interactive calcification analysis.**
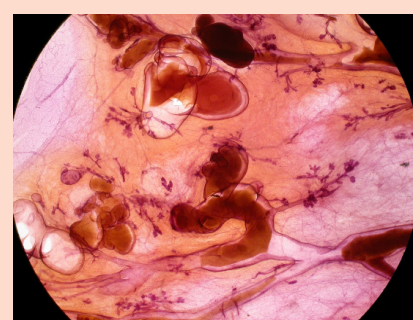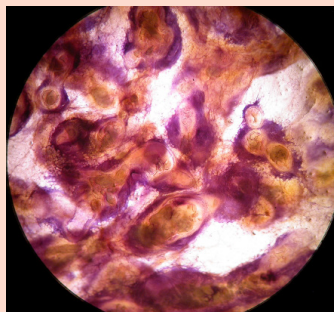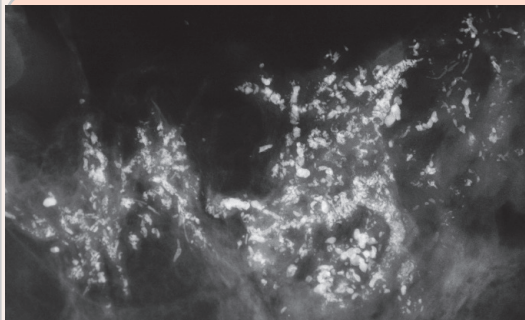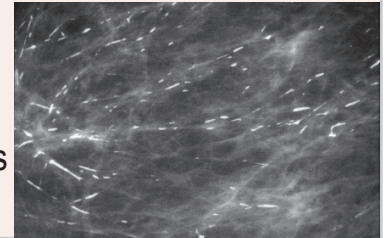
a) Fragmented casting type calcifications.
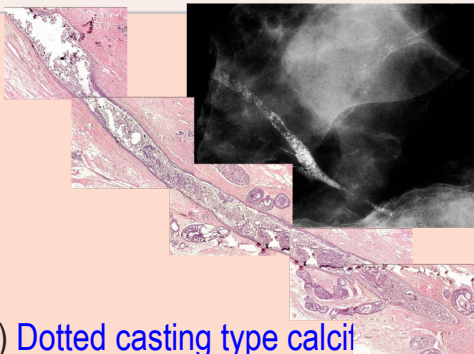
b) Dotted casting type calcif

* **Four different malignant type calcifications** developing in the major ducts: **a)** fragmented casting type **b)** dotted casting type **c)** skipping stone-like **d)** pearl necklace-like.

* The concept of **neoductgenesis**. Long-term follow-up results. New aspects, correct terminology.

* The role of breast MRI examination in demonstrating the extent of Gr 3 in situ carcinoma.

* Mammographic/3D histologic correlation helping to explain the underlying pathophysiology and outcome.
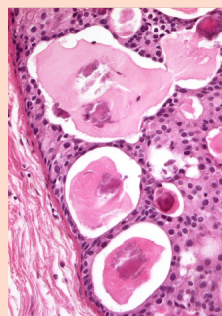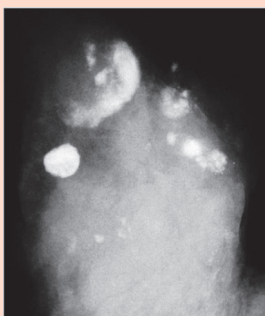
c) Skipping stone-like calcifications
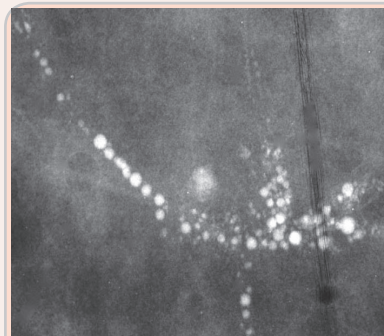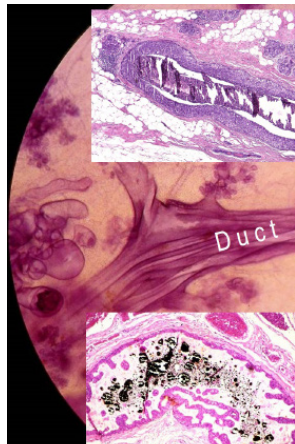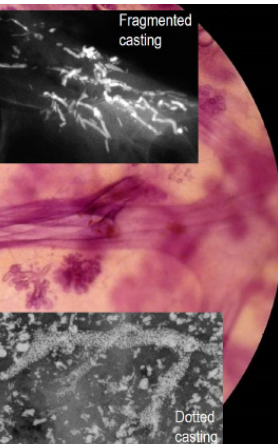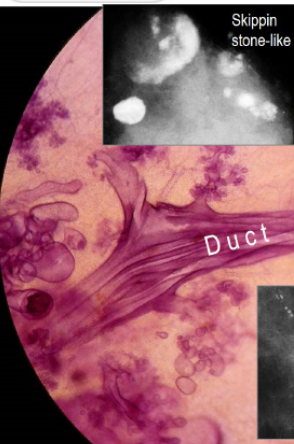
d) Pearl necklace-like calcifica-

12:00 PM - 1:00 PM   L u n c h

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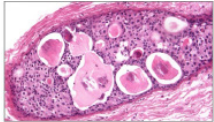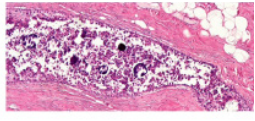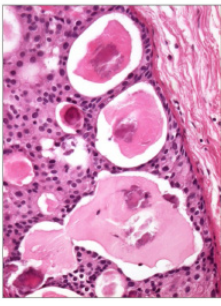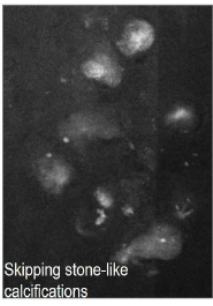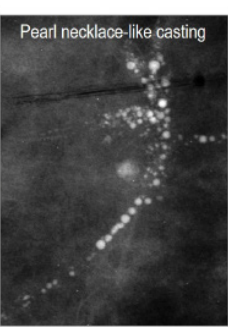
Day 2   Afternoon lectures between 1:00 PM - 5:30 PM.   Breaks: 2:30 PM, 3:30 PM

MALIGNANT:
necrosis, no fluid

Ductal Origin
Ca++ on the
mammogram

Ca++ in necrosis

Type 1
FRAGMENTED
CASTING
(solid bars)

Diffuse, lobar
disease

Grade III
solid cell
proliferation

Fragmented casting

MALIGNANT:
Necrosis, no fluid

Ductal Origin
Ca++ on the
mammogram

Ca++ in necrosis
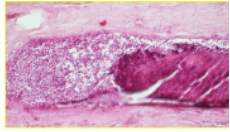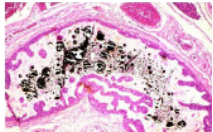
Type 2
DOTTED
CASTING-TYPE
(snakeskin-like)

-Diffuse, lobar
disease

- Grade III

-micropapillary
cell proliferation

Dotted casting

Fragmented casting

Skipping stone-like

Duct

Duct

Pearl necklace-like

Dotted casting

Interactive calcification analysis.

MALIGNANT:
No necrosis, fluid

Ductal Origin
Ca++ on the
mammogram

Ca++ in
proteinaceous fluid

Type 3
"DISCOID"
(skipping stone-like)
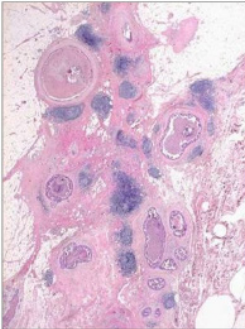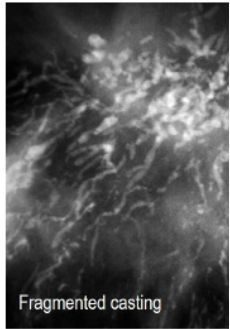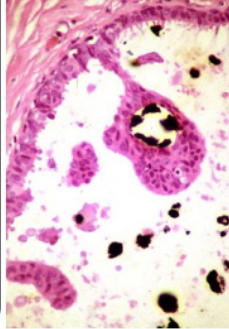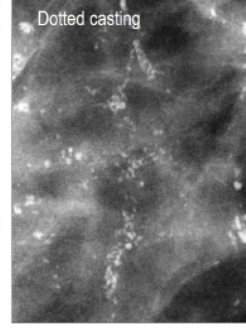
-Diffuse lobar
disease

-Grade II

-Micropapillary
or/and cribriform

Skipping stone-like
calcifications

MALIGNANT:
No necrosis, fluid

Ductal Origin
Ca++ on the
mammogram

Ca++ in
proteinaceous fluid

Type 4
"PEARL NECKLACE"

-large psammoma
body-like
calcifications within
ducts

-Grade I or/and 2

- Micropapillary,
cribriform.

Pearl necklace-like casting

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László Tabár, MD, FACR (Hon)
Course Director

ANALYSIS of MALIGNANT LESIONS PRESENTED as non-calcified RADIATING STRUCTURES on the mammogram. Clinical presentation, mammographic appearance and outcome.

- **Duct forming invasive carcinoma** / **Neoductgenesis** cases presenting on the mammogram as architectural distortion. The role of MRI in diagnosing diffuse breast cancer.

Interactive session for detecting architectural distortion on the mammogram.

Non-calcified architectural distortion: extensive duct forming invasive cancer

László Tabár, MD
Tibor Tot, MD, Peter B. Dean, MD

In 3D

Breast cancer originating from the major ducts

Ductal Adenocarcinoma
of the Breast (DAB), Part 7

Architectural distorion on the mammogram without calcifications or nipple discharge

Mammographic-MRI-subgross (3D) histologic correlation of this extensive micropapillary cancer originating from the major ducts presenting as architectural distortion.

Architectural distorion on the mammogram without calcifications or nipple discharge

In 3D

Printed in China
ISBN 978-0-9888561-0-8
50100

There are two main groups of diffuse breast cancers presenting on the mammogram as large regions of architectural distortion; these account for about 25% of all breast cancers and tend to have a poor outcome: 1) **Neoductgenesis,** i.e. "duct forming invasive carcinoma", the topic of this volume, often erroneously diagnosed as "DCIS", and 2) **Diffusely infiltrating breast cancer,** the topic of Vol. XI.
This volume demonstrates the DAB subgroup where the unnaturally high concentration of abnormal, tumor-filled ducts results in an **asymmetric density with architectural distortion on the mammogram and often causes a palpable "thickening".** Detecting architectural distortion on the mammogram and diagnosing the underlying disease correctly is a challenge for the radiologist. Breast cancers originating from the major ducts (DAB) are characterized by the formation of new, duct-like structures through the process of **Neoductgenesis.**

5:30 PM. End of Day 2.

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Day 3 Nov 19 Morning lectures between 8:30 AM - 12:00 PM.   Breaks: 10:0 AM, 11:00 AM

ASYMMETRIC DENSITIES ON THE MAMMOGRAM

- *Didactic workup of non-specific asymmetric densities **without** architectural distortion*

- *Didactic workup of non-specific asymmetric densities **with** architectural distortion*

- A suggested algorithm for the workup of lesions with architectural distortion.
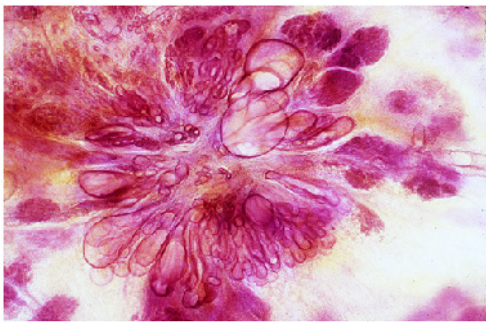
Radial scar
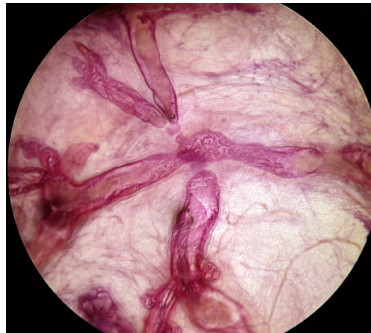
Neoductgenesis (DAB)
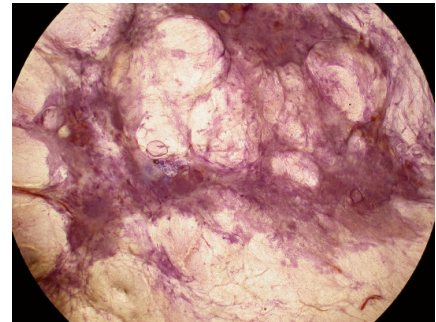
Diffusely infiltrating cancer of
mesenchymal origin

ANALYSIS of BENIGN RADIATING STRUCTURES on the mammogram, originating in the ducts:
Radial scar / sclerosing ductal hyperplasia
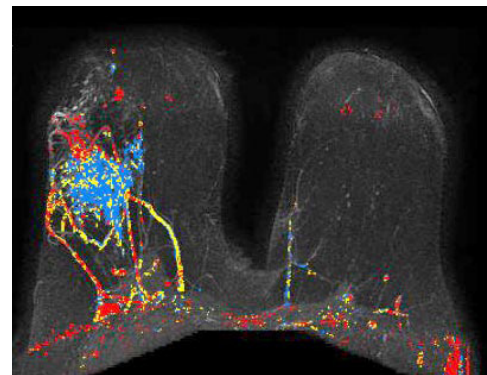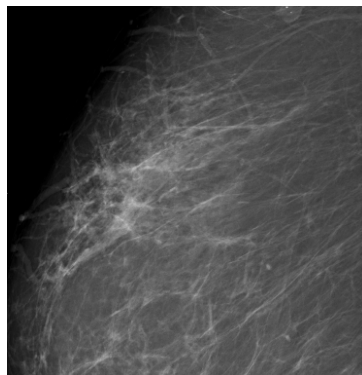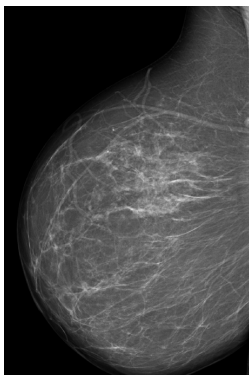
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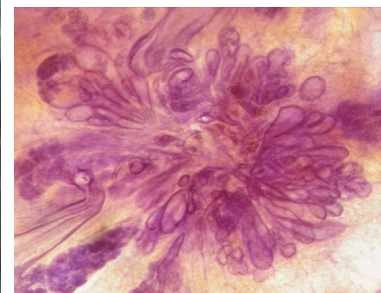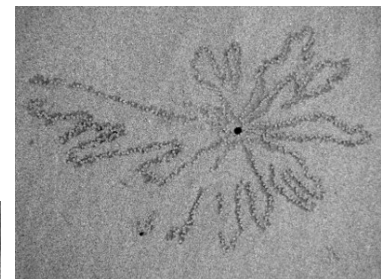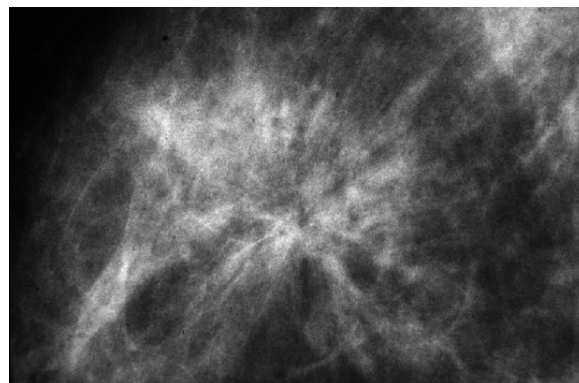
Diffusely invasive breast cancer of mesenchymal origin (a k a invasive lobular)**.**

Long-term patient outcome appears to be largely determined by the *site of origin of breast cancer*.

c) Mesenchyme (MET) (5 %)
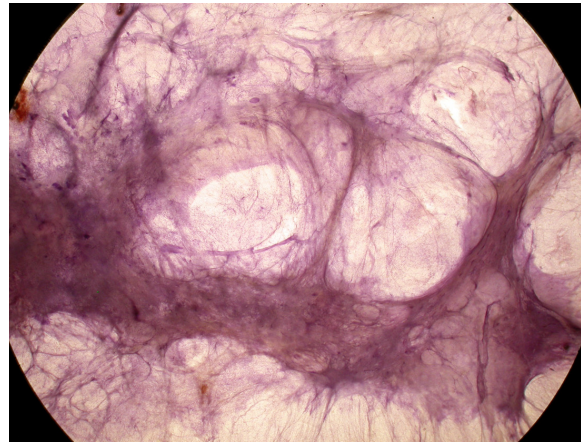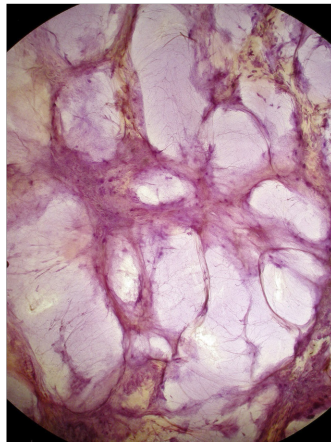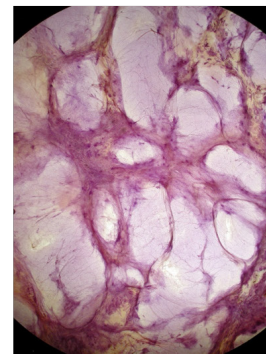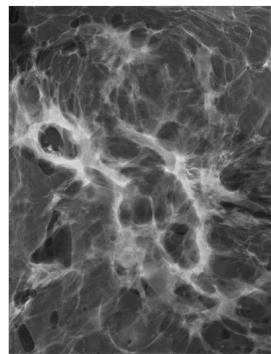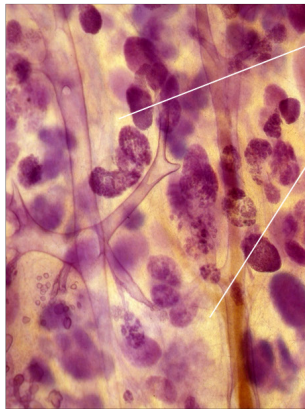
Mammographic-subgross histopathologic correlation of diffusely infiltrating breast cancer of mesenchymal origin.

mammogram and diffusely infiltrating cancers of mesenchymal origin, diagnosed in Dalarna county, Sweden between 1977-2009.

Diffusely infiltrating carcinoma MET

EMT
Casting type
Calcifications
(DAB)

Cumulative survival

Lobular with Size >=3 cm (32/149) HR=1.00
Casting (43/201) HR=1.16 (0.73-1.84)

Years of follow-up

12:00 PM - 1:00 PM L u n c h

XV

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Detection and Diagnosis of Breast Diseases
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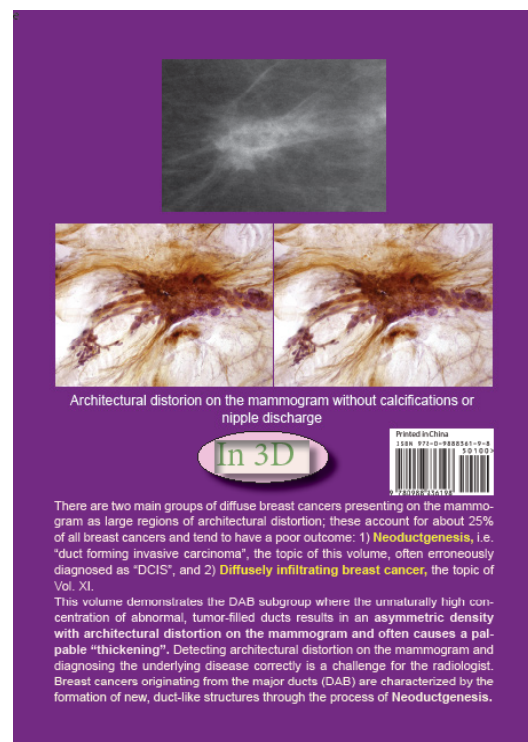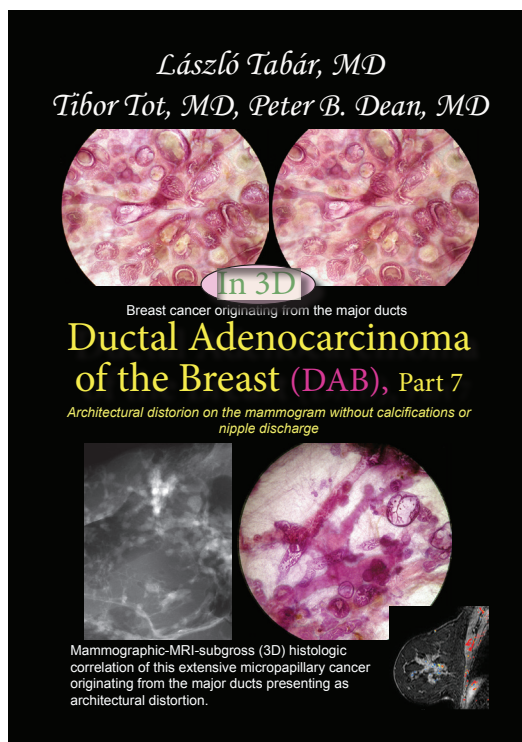**László Tabár, MD, FACR (Hon)**
Course Director
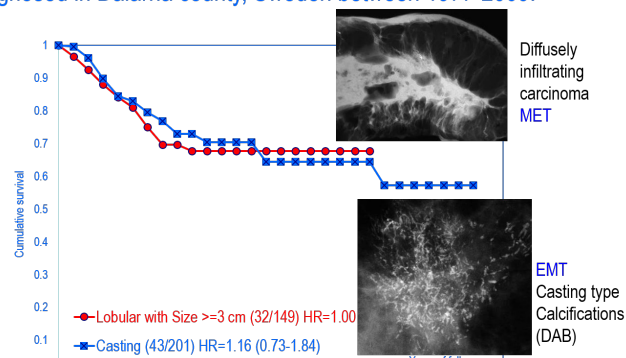
Day 3   Afternoon lectures between 1:00 PM - 4:30 PM.   **Breaks: 2:00 PM, 3:00 PM**

ANALYSIS of MALIGNANT LESIONS PRESENTING as RADIATING STRUCTUREs on the mammogram. Clinical presentation, mammographic appearance and outcome, cont.

2) Diffusely infiltrating breast cancer of mesenchymal origin: the most deceptive and frequently missed cancer of the breast. The value of ultrasound and MRI in finding and diagnosing this spider's web-like malignancy. Case demonstrations, large section histopathologic-imaging correlation. Long-term outcome.
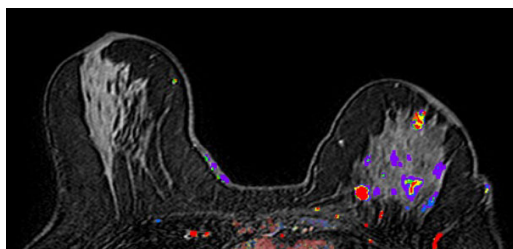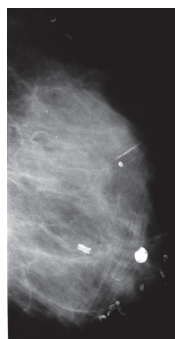
Example 1. Multimodality workup of a huge diffusely infiltrating breast malignancy of mesenchymal origin.
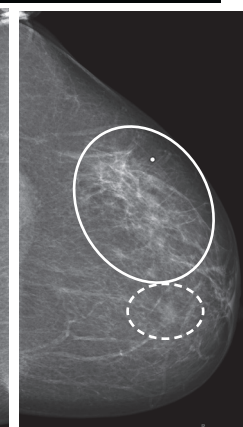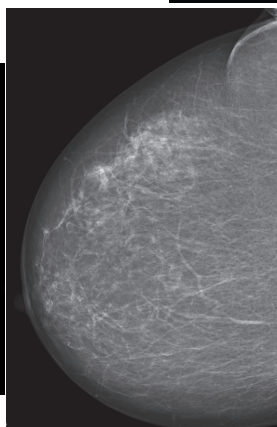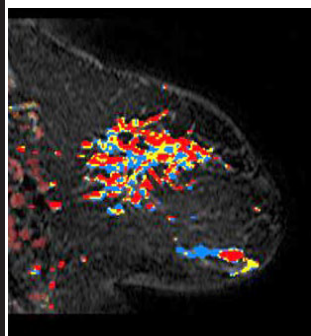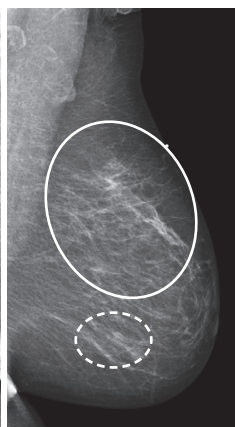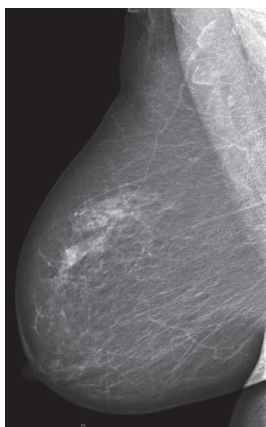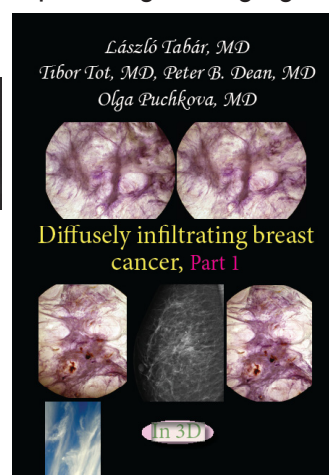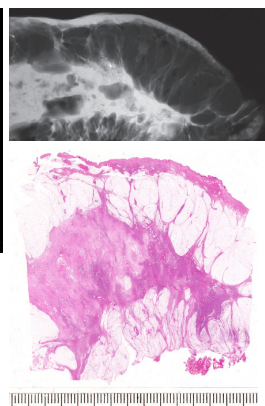
Example 2. Diffusely infiltrating (spider's web-like) carcinoma of mesenchyal origin in the upper half of the breast and a shperical, round lesion, originating from the TDLU (AAB) is seen in the lower portion of the left breast.
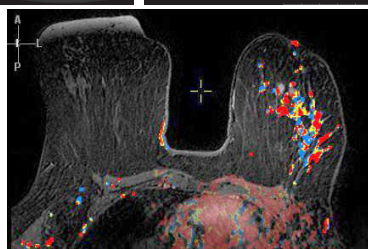
Interactive session for detecting architectural distortion on the mammogram.

4:45   ART HISTORY LECTURE: - A FRIGERIO

5:30   End of the lectures for Day 3

![MEI Mammography Education Inc logo]

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Course Director

Day 4 Nov 20 **Morning lectures between 8:30 AM - 1:00 PM.** **Breaks: 10:00 AM, 11:00 AM**

ALGORITHM FOR CLASSIFYING BREAST DISEASES ACCORDING TO THEIR SITE OF ORIGIN

· **Benign breast diseases originating in the TDLU** and associated with calcifications
on the mammogram   -

- **Fibrocystic change. Fibroadenoma. Different types of adenosis.** Understanding
pathophysiology leading to calcified and non-calcified hyperplastic breast changes.

body-like calcifications, seen as "teacup-like calcifications on the mammogram.

- Detailed analysis of calcifications associated with hyperplastic breast changes: Weddellites (A),
powdery calcifications (B), cluster skipping stone-like calcifications on the mammogram.
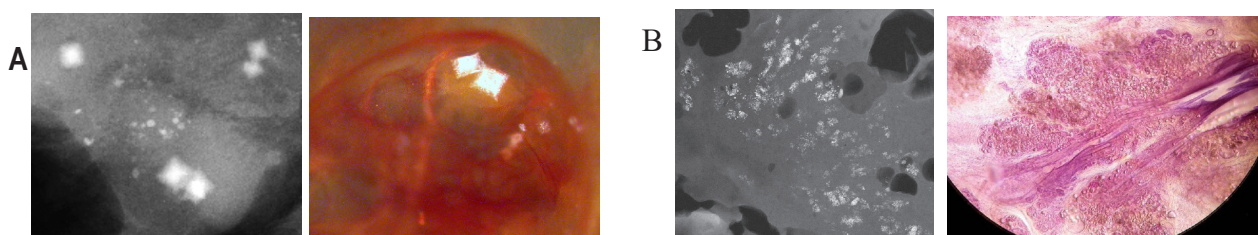
· The morphologic analysis of calcifications representing a less aggressive carcinoma:
Grade 1 / well differentiated CIS
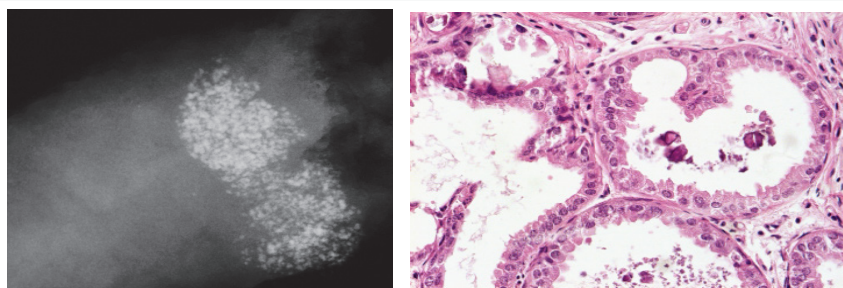
Grade 1 *in situ* carcinoma:
Mammographic / 3D histo-
logic / MRI correlation
of cases with powdery calcifi-
cations on the mammogram.

XVII

2020
BREAST SEMINAR SERIES of MEI

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Mammographic / histopathologic correlation of pleomorphic calcifications representing Gr 2 CIS within the TDLU
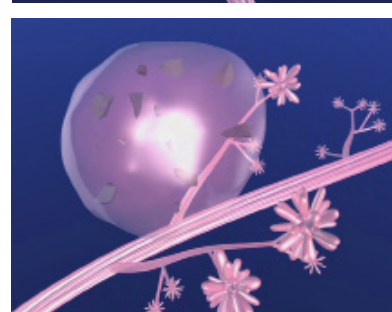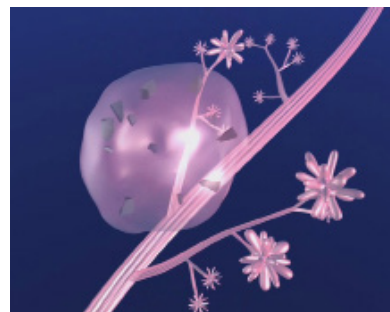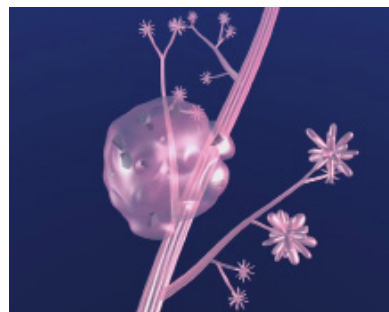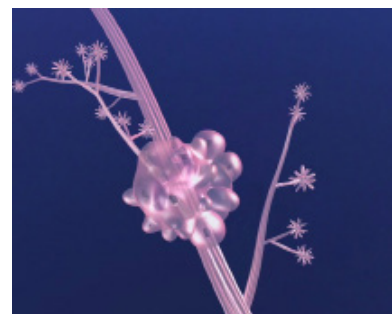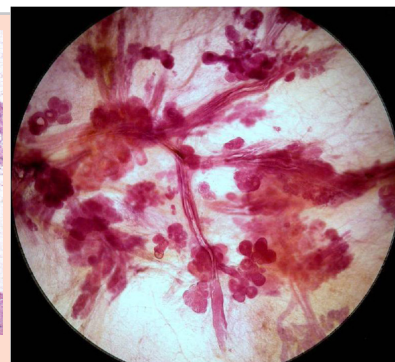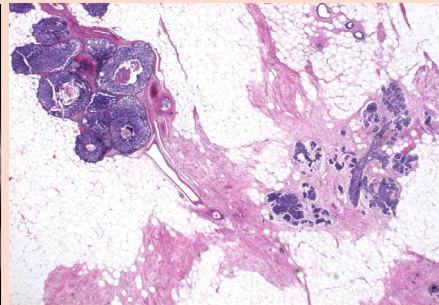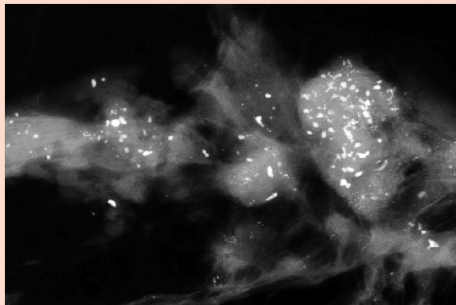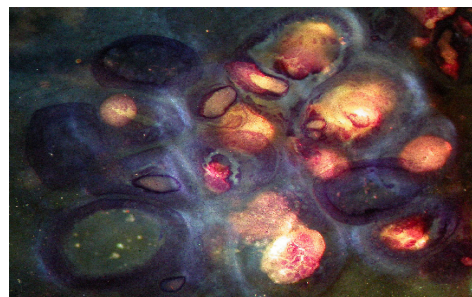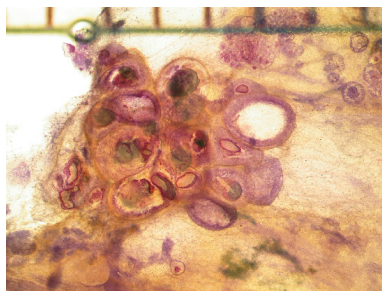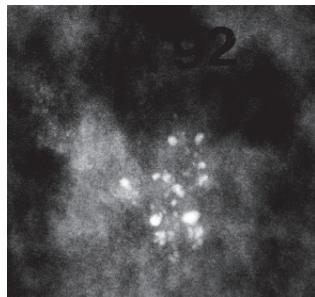
Computer simulation images of the development of Grade 2 *in situ* carcinoma within the TDLU. The lobule becomes gradually distended and deformed. Calcifications are formed within the necrotic debris and are seen on the mammogram as **crushed stone-like calcifications**.

1:00 End of the course

MEI MAMMOGRAPHY EDUCATION INC

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Course Director

For more information and registration please contact:

**Korilù srl
Provider N 5798
Via Belmeloro 5 - 40126 Bologna
www.korilu.it - congressi@korilu.it
tel 051385328 - 051387615**

A photograph from the collection of the non-profit Tabar Foundation dedicated to Research
and Education for Breast Cancer

XIX

DETECTION AND DIAGNOSIS OF BREAST DISEASES USING THE MULTIMODALITY APPROACH   Breast Seminar series of MEI

Torino, 17 - 20 novembre 2020

MEI Mammography Education, Inc.

korilù realizziamo idee

SCHEDA DI ISCRIZIONE

Inviare alla Segreteria Organizzativa Korilù srl - Via Belmeloro 5- 40126 Bologna Tel. 051 385328 - congressi@korilu.it - www.korilu.it

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Nato a .... il .... Codice Fiscale | | | | | | | | | | | | | | | | | | | | | | | | | |

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CAP | | | | | | Città .... Prov. ....

Professione .... Disciplina ....

❑ Libero Professionista ❑ Dipendente ❑ Convenzionato **Iscritto all'ordine/collegio/ass. prof.le n.** ....di (città)...

Ente ....

Città Ente...

QUOTA DI ISCRIZIONE

L'iscrizione dà diritto a: partecipazione ai lavori scientifici, kit congressuale, colazione di lavoro, coffee break, attestato di partecipazione

❑ *Medico Chirurgo*   €995,00 + €10,00 di spese

❑ *Specializzando e TSRM*   €895,00 + €10,00 di spese

IMPORTANTE: chi desidera ricevere fattura anziché ricevuta dovrà aggiungere alla quota di iscrizione il corrispettivo dell'IVA vigente al 22% e compilare la parte dedicata ai DATI PER LA FATTURAZIONE. Pertanto il totale diventerà:
€ 1.005,00 + IVA 22% = € 1.226,10 per Medico Chirurgo e € 905,00+ IVA 22% = € 1.104,10 per il Medico Specializzando e TSRM

DATI PER LA FATTURAZIONE ELETTRONICA (OBBLIGATORIA PER EMISSIONE FATTURA INDIRIZZO PEC E CUU)

(Ragione Sociale o Cognome e Nome): ....

Via .... CAP | | | | | | Città .... Prov. ....

Partiva IVA | | | | | | | | | | | | Codice Fiscale | | | | | | | | | | | | | | | | |

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Non è possibile richiedere emissione di nota di accredito a pagamento e/o fatturazione già avvenuta.

Note :

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PEC ....Codice Destinatario..

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